Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST, LLC
PO BOX 890008
HOUSTON, TX 77289

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

54

MFDR Tracking Number

M4-12-0337-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On October 27, 2010, Healthtrust performed this 8 unit procedure for the above listed patient. On November 19, 2010, HealthTrust mailed out his claim, along with 11 other claims to the carrier-Texas Mutual Insurance Company…The other claims from that day's mail receipts have already been processed by the carrier, which would indicate that they were in receipt by the carrier."

Amount in Dispute: $1,560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the documentation submitted by the requestor does not validate its timely submission of the bill."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2010	97799-CP	$1,560.00	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of Workers' Compensation

Specific Services provided on or after March 1, 2008.

5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 06/06/2011
   - CAC-29- The time limit for filing has expired.
   - 731- Per 133.20 Provider shall not submit a medical later than the 95th day after the date the service, for services on or after 9/1/05

   Explanation of benefits dated 09/21/2011
   - CAC-193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-29- The time limit for filing has expired.
   - 731- Per 133.20 Provider shall not submit a medical later than the 95th day after the date the service, for services on or after 9/1/05
   - 891- No additional payment after reconsideration

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service (USPS) regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the Requestor finds a copy of a medical bill with printed date 10/28/10 in box 31 and a copy of an itemized statement of bills that were sent on the 11/19/10 which includes the bill in dispute for date of service 10/27/2010, along with a copy of the USPS Certified Mail receipt signed by respondent on November 23, 2010. Pursuant to Texas Labor Code §408.027 and 28 Texas Administrative Code § 102.4(h) the documentation submitted by the requestor sufficiently supports that the requestor submitted a bill for the disputed dates of service to the insurance carrier within 95 days after the date services were provided.
3. A review of the requestor's submitted documentation sufficiently supports the services were rendered as billed. Reimbursement for a Non-CARF accredited facility is at $100.00 per hour in accordance with 28 Texas Administrative Code § 134.204 (h)(1)(B). The MAR amount is $100.00/hr x 8 hrs= $800.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent

to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/23/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.